Admiral INSURANCE GROUP
a Berkley Company

PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY APPLICATION

(CLAIMS MADE AND REPORTED COVERAGE)

SECTION I – GENERAL INFORMATION

1) Full Name of Applicant:

DBA (if applicable):

2) Principal Office Address:

3) Home Address:

4) Website address (if applicable):

5) Date of Birth: Place of Birth: Social Security #:

6) Are you a U.S. citizen? ◯ Yes ◯ No

If No, indicate your status and date of entry into the United States:

7) List the States and license numbers where you practice:

8) DEA Number:

9) Professional training – or attach a current Curriculum Vitae (CV) and skip questions 9 – 13.

	School or Facility	Location	Specialty	Start Date	Completion Date
Medical School					
Internship					
Residency					
Fellowship					
Other Training					

10) Additional medical training? ◯ Yes ◯ No

If Yes, provide details including type, location and date of training:

11) Where have you practiced your profession since completion of training:

In: From: To:

In: From: To:

In: From: To:

12) Are you American Board Certified? ◯ Yes ◯ No

Medical Specialty: _____ Date Certified: _____

Medical Specialty: _____ Date Certified: _____

13) Indicate memberships in professional societies:

_____

14) What is your medical or surgical specialty? _____

Percentage dedicated to this specialty? _____ %

15) What is your subspecialty? _____

Percentage dedicated to this specialty? _____ %

16) Do you limit your practice to the above specialties? ◯ Yes ◯ No

If No, what other specialties do you practice? Provide details:

_____

SECTION II – PRACTICE INFORMATION

17) Including your own individual legal entity(s), please provide the names of all current practice locations, along with your interest in each. State whether or not you are seeking coverage for your services at each. Please add a separate attachment if necessary.

Name of Entity or Facility and Location	Interest (Employee, Independent Contractor, Partner, Owner)	% of Ownership	Are you seeking coverage for your services at this facility?*	Should the entity or facility be included for coverage?
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No
			◯ Yes ◯ No	◯ Yes ◯ No

* For all No answers, please provide evidence of coverage in place elsewhere.

18) For the entities/facilities at which you are seeking coverage, please advise the following:

a) Approximately how many hours per week will you be working? _____

b) The number of weekly non-surgical patient encounters seen by you? _____

c) The number of weekly surgeries performed by you: _____

19) For those entities/facilities that should also be included for coverage, please advise the following:

a) The number of weekly patient encounters for all staff:

20) Are you contracted as Medical Director for any facilities? ◯ Yes ◯ No
If Yes, please provide names of each facility:

Should coverage extend to these services? ◯ Yes ◯ No
If Yes, please provide copies of all contracts, including scope of work.

21) Do you provide any of the following?

		Are services provided?	Is coverage needed?	If Yes, please provide a summary of the services to be included for coverage
a)	Services at, or for, Long term care facilities?	◯ Yes ◯ No	◯ Yes ◯ No	
b)	Services at, or for, Correctional facilities?	◯ Yes ◯ No	◯ Yes ◯ No	
c)	Any Obstetrical and/or Prenatal care?	◯ Yes ◯ No	◯ Yes ◯ No	
d)	Contracted or employed by a governmental entity?	◯ Yes ◯ No	◯ Yes ◯ No	

22) Do you currently have privileges in any hospital? ◯ Yes ◯ No
If Yes, please provide the following details:

(a) List the hospitals at which you are currently a staff member:

(b) Briefly describe the type and extent of your hospital privileges:

(c) Are you Chief or Head of a hospital department? ◯ Yes ◯ No

If Yes, which department(s):

Is coverage needed for these services? ◯ Yes ◯ No

(d) Do you provide services in any hospital emergency room work? ◯ Yes ◯ No

If Yes, is the emergency room care:

1) Only for your own patients? ◯ Yes ◯ No
2) Required for staff privileges? ◯ Yes ◯ No
3) How many hours per month?
4) Does the hospital cover you for malpractice while you work in the emergency room? ◯ Yes ◯ No
5) Are you requesting coverage for your emergency room work? ◯ Yes ◯ No

23) Do you offer professional advice to the public such as through a website, radio or TV broadcasts, newsletters, etc.? ◯ Yes ◯ No
If Yes, provide details:

24) Do you advertise or prescribe any off-label use of drugs? ◯ Yes ◯ No

25) Do you anticipate any changes in your practice? ◯ Yes ◯ No

If Yes, provide details:

SECTION III – STAFF

26) Please provide the number of professionals you employ or with whom you contract to provide services, and state whether they carry their own medical malpractice coverage.

	Employed	Contracted	Carry their own Med Mal policy*?
Physicians			◯ Yes ◯ No
Physician Assistants			◯ Yes ◯ No
Nurse Practitioners			◯ Yes ◯ No
Surgical Assistants			◯ Yes ◯ No
CRNA's			◯ Yes ◯ No
Chiropractors			◯ Yes ◯ No
RN's			◯ Yes ◯ No
LPN's, Nurse Aides			◯ Yes ◯ No
Other:			◯ Yes ◯ No
Other:			◯ Yes ◯ No

*Attach copies of declarations pages on above professionals that carry their own malpractice policies.

27) Are all of the above individuals licensed in accordance with applicable state and federal regulations? ◯ Yes ◯ No

If No, attach an explanation.

28) If you included any Physician Assistants or Nurse Practitioners above, do you maintain practice agreements, delegation of service agreements, collaboration agreements, or the equivalent with such providers where/as required by state law? ◯ Yes ◯ No

If Yes, please attach a list of all that qualify.

SECTION IV – NON SURGICAL PROCEDURES

29) Does your practice include prescribing of opioids? ◯ Yes ◯ No

If Yes, provide the following details:

(a) Specify the percentage of your practice derived from opioid prescriptions %

(b) Do you full comply with the CDC Guideline for Prescribing Opioids? ◯ Yes ◯ No

(c) Does your practice adhere to any and all prescription drug monitoring program (PDMP) requirements in the state(s) where you conduct business? ◯ Yes ◯ No

(d) Do you also dispense the opioids? ◯ Yes ◯ No

Pain Management

30) Does your practice include Pain Management? ◯ Yes ◯ No

If Yes, please provide the following details:

(a) What percent is from Prescription Only Pain Management. %

(b) Please indicate the procedures you perform:

CATEGORY 1:

- ☐ Facet Joint Blocks
- ☐ Lesioning
- ☐ Percutaneous Discectomy
- ☐ Percutaneous Endoscopic Nerve Root Decompression
- ☐ Peripheral Nerve Block
- ☐ Radio Frequency Nerve Ablation
- ☐ Rapid Opiate Detoxification
- ☐ Selective Nerve Root Block
- ☐ Sympathetic Blocks
- ☐ Trigger Point Injections

CATEGORY 2:

- ☐ Dorsal Column Simulator Implants/Reprogramming
- ☐ Epidural or Spinal Catheters
- ☐ Intradiscal Electrothermal Therapy
- ☐ Peripheral Nerve Stimulation
- ☐ Spinal Infusion Implants/Pumps; Removal, Refilling/Reprogramming
- ☐ Vertebroplasty
- ☐ Discectomy

Weight management

31) Does your practice include weight management? ◯ Yes ◯ No

If Yes, please provide the following details:

(a) Please specify the percentage of patients that are exclusively treated for weight control (other than by just diet and exercise): ____ %

(b) Do you prescribe any weight control drugs? ◯ Yes ◯ No

If Yes, list drugs prescribed:

(c) Do you dispense supplements for weight control? ◯ Yes ◯ No

If Yes, list supplements dispensed:

(d) Do you provide injections for weight control? ◯ Yes ◯ No

If Yes, list the medications in use:

Alternative and Other Procedures NOC

32) Please mark all procedures that may apply to your practice.

NOTE: If you practice other treatments that are considered "alternative", please fill them in under OTHER.

If None, please check this box and proceed to question 33 ☐

- ☐ Abortion or Abortion reversal medication
- ☐ Acupuncture
- ☐ Alternative Cancer Treatments NOC –
  Describe:
- ☐ BHRT pellets / Testosterone injections
- ☐ Botox Injections for Pain or Cosmetics
- ☐ Chelation Therapy
- ☐ Chemobrasion / Dermabrasion
- ☐ COVID 19 treatments – describe:
- ☐ Cryotherapy
- ☐ Electroshock Therapy
- ☐ Erectile Dysfunction treatments
- ☐ Hair transplants
- ☐ HBOT:
  - ☐ Elective
  - ☐ Wound care
- ☐ Hypnotherapy
- ☐ IV Hydration / vitamin injections
- ☐ Other – describe:
- ☐ Ketamine Therapy
- ☐ Lithotripsy
- ☐ Medical Marijuana Evaluations
- ☐ Mesotherapy
- ☐ Naturopathy/Homeopathy/Herbal Medicine
- ☐ Needle biopsies
- ☐ Neural Therapy
- ☐ Osteopathic / Chiropractic Manipulation – No Anesthesia
- ☐ Osteopathic / Chiropractic Manipulation Under Anesthesia
- ☐ Ozone Therapy
- ☐ Prolotherapy
- ☐ Rapid Opiate Detoxification
- ☐ Sclerotherapy
- ☐ Transcranial magnetic stimulation (TMS)

Regenerative Medicine

33) Do you perform any procedures using stem cells, exosomes or any derivative? ◯ Yes ◯ No

If No, please skip this section and proceed to question #43.

34) Do you perform any stem cell transplantation or treatments *other than* autologous? ◯ Yes ◯ No

If Yes,

(a) What type of stem cell products are you using?

(b) Describe accredited training and experience for all persons providing the procedures listed on this questionnaire.

(c) Where do you purchase your stem cell products? (List all vendors)

(d) Are all vendors FDA Regulated/FDA Approved? ◯ Yes ◯ No

(e) Are all of the above-listed stem cell products FDA approved? ◯ Yes ◯ No

(f) Have all stem cell products been tested for viral, bacterial or fungal infections? ◯ Yes ◯ No

35) What type of stem cell procedures/treatments are being performed including which ailment or condition are they meant to treat?

(a) Have such procedures undergone clinical trials and have they been FDA approved? ◯ Yes ◯ No
If No, provide details:

(b) Do you process and use the Stem Cells during the same visit in which they were collected? ◯ Yes ◯ No
If No, do you have a formal chain of custody procedure to make sure collected stem cells are only used by the donor? ◯ Yes ◯ No
Please provide details:

36) Describe accredited training and experience for all persons providing the procedures listed on this questionnaire. Please provide any training documentation.

37) What type of laboratory stem cell processing equipment is used?

38) Is your office/clinic adequately prepared and have procedures in place to handle emergencies such as adverse reactions to procedures/treatments? ◯ Yes ◯ No

39) Do you or any employees currently participate or are involved in stem cell treatment related to clinical trials? ◯ Yes ◯ No
If Yes, provide details:

40) Do you use an informed consent for every stem cell treatment you offer? ◯ Yes ◯ No

41) Do you advertise your stem cell treatments? ◯ Yes ◯ No

42) Do you or your principals have ownership interest in any other stem cell related business, research facilities or manufacturing operations? ◯ Yes ◯ No
If Yes, provide details:

SECTION V – SURGERY

43) Do you perform any type of surgery including minor surgery other than incision of boils and superficial abscesses or suturing skin and superficial fascia? ◯ Yes ◯ No

44) Do you assist in surgery:
On your own patients? ◯ Yes ◯ No
On patients of others? ◯ Yes ◯ No

If No to both, please skip questions 45 - 48. If Yes to either, please continue with the questions below.

45) Do you perform surgery in your office? ◯ Yes ◯ No
If Yes, list the surgical procedures:

46) Do you perform surgery in other non-hospital facilities? ◯ Yes ◯ No
If Yes, what type of facility and list the surgical procedures:

47) In the course of surgery, does a Board Certified Anesthesiologist provide the anesthesia? ◯ Yes ◯ No
If No, provide details:

48) Surgical Procedures – please check all that apply, and provide additional details where requested

- ☐ Abortions
- ☐ Angioplasty
- ☐ Bariatric surgery – list procedures
- **Cosmetic Surgery**
  - ☐ Breast Augmentation
  - ☐ Breast Reduction
  - ☐ Fat Recycling – what body parts
  - ☐ Liposuction – max cc's
  - ☐ Silicone Implants – what body parts
  - ☐ Penile Lengthening / enhancements
  - ☐ Other cosmetic surgeries – list
- ☐ Plastic Surgery - NOC
  - % of Reconstructive
  - % of Elective
- ☐ Angiography / Arteriography
- ☐ Cardiac Catheterization
- ☐ Cholecystectomies
  - ☐ Laparoscopic
    - # performed last 12 mos:
- ☐ Cryosurgery / Malignant Lesions
- ☐ D&C
- ☐ Endoscopic Procedures
- ☐ Fertility / Infertility treatments
- ☐ Hysterectomies
  - ☐ Laparoscopic
  - ☐ Other:
- ☐ Interventional Radiology
- ☐ Neurosurgery
- ☐ Orthopedic surgery
  - ☐ Spine
  - ☐ No spine surgery
- ☐ Organ transplants

☐ Radiation Therapy including implants

☐ Research / Clinical trials

☐ Surgical procedures for research – provide details:

☐ Sex change operations – list procedures

☐ Spinal Surgery

☐ Tonsillectomies / Adenoidectomies

☐ Vasectomies / reversals

☐ Vision correction - list procedures:

☐ Vascular / Thoracic Surgery

☐ Other surgical procedures not listed above:

SECTION VII – PAST INFORMATION

49) Have you, or any of your employees: (If Yes, attach details.)

(a) Ever been subject of investigation or disciplinary proceedings or reprimanded by a governmental or administrative agency, hospital or professional association? Attach a copy of Complaint and Consent Order document if applicable. ◯ Yes ◯ No

(b) Ever been convicted for an act committed in violation of any law or ordinance other than traffic offenses? ◯ Yes ◯ No

(c) Ever been treated for alcoholism or drug addiction or undergone personal psychiatric treatment or has any administrative agency, hospital or professional association requested or required you be evaluated for an alleged mental condition and/or alcohol or drug addiction? ◯ Yes ◯ No

(d) Ever had any state professional license or license to prescribe or dispense narcotics refused, suspended, revoked, renewal refused or accepted only on special terms or ever voluntarily surrendered same? ◯ Yes ◯ No

(e) Ever had any professional liability insurance cancelled, declined, refused to renew or accepted only on special terms? ◯ Yes ◯ No

(f) Ever failed any medical licensing or specialty organization examination? ◯ Yes ◯ No

50) List the prior medical malpractice insurance carried for each of the past 5 years beginning with the most current:

Company	Policy Term	Limits of Liability	Retro Date	Premium

*Attach a copy of the declarations page of your most recent policy.

51) Has any claim or suit for alleged malpractice been brought against you? ◯ Yes ◯ No

If Yes, how many total claims or incidents?

Please complete the Supplemental Claim Information Form for each and every claim.

52) Do you have any open claims? ◯ Yes ◯ No

53) Has any claim or suit for alleged malpractice been made against you that has NOT been reported to a prior insurer? ◯ Yes ◯ No

54) Are you aware of any acts, errors, omissions or circumstances which may result in a malpractice claim or suit being made or brought against you? ◯ Yes ◯ No
If Yes, provide details including name of claimant, date of occurrence, date of first contact, allegation, and current status of incident:

SECTION VI – COMMENTS

Please provide any additional information that we should consider when reviewing your application for coverage. (For example, only consider specific job, detailed explanation of the coverage needed, other procedures performed or types of treatment provided that were not mentioned above, further detail on any of the answers above, etc)

Please attach the following information:

- CV or Resume
- Currently valued loss runs for the last 7 years.
  - If not available, we will need a self-inquiry from the NPDB in addition to the available loss runs
  - Link for the NPDB report is: https://www.npdb.hrsa.gov/ext/selfquery/SQHome.jsp
- Copies of any disciplinary actions, stipulation orders or probation documents
- Copies of declarations pages for all employees or contractors that carry their own Medical Malpractice
- Copy of your most recent Medical Malpractice declarations page

Fraud Notices

Applicable in AL, AR, DC, LA, MD, NM, RI and WV: Any person who knowingly (or willfully)* presents a false or fraudulent claim for payment of a loss or benefit or knowingly (or willfully)* presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. *Applies in MD only.

Applicable in CO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

Applicable in FL and OK: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony (of the third degree)*. * Applies in FL only.

Applicable in KS: Any person who knowingly and with intent to defraud, presents, causes to be presented, or prepares with knowledge or belief that it will be presented, to or by an insurer, purported insurer, broker or any agent thereof, any written statement as part of, or in support of, an application for the issuance of, or the rating of an insurance policy for personal or commercial insurance, or a claim for payment or other benefit pursuant to an insurance policy for commercial or personal insurance which such person knows to contain materially false information concerning any fact material thereto; or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act.

Applicable in KY, NY, OH and PA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties (not to exceed five thousand dollars and the stated value of the claim for each such violation)*. *Applies in NY only.

Applicable in ME, TN, VA, and WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties (may)* include imprisonment, fines and denial of insurance benefits. *Applies in ME only.

Applicable in NJ: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Applicable in OR: Any person who knowingly and with intent to defraud or solicit another to defraud the insurer by submitting an application containing a false statement as to any material fact may be violating state law.

Applicable in PR: Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances [be] present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Applicable in all other States: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance, or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent insurance act, which is a crime and may also be subject to civil penalty.

Other State Notices

Applicable in RI: THIS INSURANCE CONTRACT HAS BEEN PLACED WITH AN INSURER NOT LICENSED TO DO BUSINESS IN THE STATE OF RHODE ISLAND BUT APPROVED AS A SURPLUS LINES INSURER. THE INSURER IS NOT A MEMBER OF THE RHODE ISLAND INSURERS INSOLVENCY FUND. SHOULD THE INSURER BECOME INSOLVENT, THE PROTECTION AND BENEFITS OF THE RHODE ISLAND INSURERS INSOLVENCY FUND ARE NOT AVAILABLE.

I/We understand that this is an application for insurance only and that the completion and submission of this Application does not bind the Company to sell nor the applicant to purchase this insurance. I/We hereby declare that the above statements and particulars are true and I/we agree that this Application shall be the basis for any contract of insurance issued by the Company in response to it.

Electronic Signature of Applicant or Authorized Representative:

Title: Date:

If you prefer not to return the questionnaire with an electronic signature, please print and sign.

SUPPLEMENTAL CLAIM INFORMATION FORM
(COMPLETE ONE FORM FOR EACH CLAIM, POTENTIAL CLAIM OR INCIDENT)

1) Name of applicant/named insured:

2) Name of other parties of defendants named in suit:

3) Date of alleged error or occurrence, or contract date:

4) Date claim was made:

5) Name of Claimant:

6) Name of Insurance Company handling your claim:

7) Present Status of claim for final disposition and explain: ☐ Closed ☐ Open

8) Defense costs paid to date inclusive of any deductible:

9) If closed, total loss paid, inclusive of any deductible:

10) If claim is open or pending, what are the insurer's reserves?

Defense: Loss:

11) Description of case and events including allegations and assessment of liability:

12) Claimant's last settlement demand:

13) Steps taken to avoid a similar incident: